TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Baylor Orthopedic & Spine Hospital

Respondent Name
Crowley ISD

MFDR Tracking Number
M4-18-0920-01

Carrier's Austin Representative
Box Number 43

MFDR Date Received
December 5, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are requesting 130% of the Medicare allowable with implant reimbursement: Total reimbursement due = $12,185.97."

Amount in Dispute: $5,553.51

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill was sent in for reconsideration and received on 11/09/2017. The request contained the implant log and Purchase order but not manufacturer's invoice therefore the reconsideration did not allow additional information. …After review of the Request for Medical Fee Dispute Resolution, Careworks stands on the original denial for lack of Manufactures Cost Implant Invoice."

Response Submitted by: CareWorks, 10535 Boyer Blvd, Suite 100, Austin, TX 78758

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 11, 2017	C1713, C1762	$5,553.51	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the acute care hospital fee guideline for outpatient services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 16 – Claim/service lacks information which is needed for adjudication.

- 226 – Information requested from the billing/rendering provider was not provided or was insufficient/incomplete
- 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly
- W3 – Additional payment made on appeal/reconsideration

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?

Findings

1. The insurance carrier reduced or denied payment for disputed services with claim adjustment reason code 16 – "Claim/service lacks information which is needed for adjudication" and 226 – "Information requested from the billing/rendering provider was not provided or was insufficient/incomplete."

   28 Texas Administrative Code §134.403 (g) requires that

   > Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice a mount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission."

   Review of the submitted information finds that this request for medical fee contained the following:

   - Print screen from Materials management
   - Purchase order from Zimmer Biomet

   Neither of these documents meet the requirements of 28 Texas Administrative Code §134.403 (g). The insurance carrier's denial reason is supported. Additional reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		December 29, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.